



EMPLOYEE'S REPORT OF INJURY

Please Print

Employee's Name _____ Date _____
(Last, First, Middle)

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Social Security # _____

Date of Birth _____ Sex _____ Date of Hire _____

Occupation _____ Work Number _____

Cell or pager# _____ Marital Status _____ #Dependents _____

Date of accident _____ Time began work _____ Time of Occurrence ____ am ____ pm

Injury _____ Exposure _____ Illness _____ Any loss days – No ____ Yes ____

Dates Days Missed _____

Location where accident occurred _____

City _____ State _____

Date / Time Accident Reported _____ To Whom? _____

Name(s) of Witness(es) _____

Describe in detail what happened and what part of the body was injured: _____

Employee's Report of Injury Continued:

Date and time you first sought medical attention_____

Name of Doctor and/or Hospital_____

What could have been done to prevent this accident?_____

Signature of Employee_____Date_____